LETTERS FROM EUROPE

by John A. Koltes, M. D.

OBSERVATIONS AND IMPRESSIONS OF SOME EUROPEAN PSYCHIATRIC HOSPITALS AND PROGRAMS AS RECORDED IN PERSONAL LETTERS TO THE MEDICAL DIRECTOR OF THE EASTERN PENNSYLVANIA PSYCHIATRIC INSTITUTE.

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30 Woodcote Grove Road
Coulsdon, Surrey, England
July 21, 1955

Dear Dr. Davis:

We are comfortably settled in our house that Dr. Max Jones located for us and I'm hard at work learning the methods of the Therapeutic Community. Coulsdon is a suburban village south of London in the heart of the Surrey hills. It is a lovely spot, the neighbors are very friendly and interested in the activities of "those Americans."

Let me give you a breakdown of events to date. The Therapeutic Community (Social Rehabilitation Unit) consists of 100 beds in a wing of an old state hospital (the Belmont Hospital). The hospital is given entirely to the treatment of neuroses except for the Unit which treats patients who have failed to maintain employment status, patients who are alcoholics, psychopaths, homosexuals, etc. There are both men and women in the Unit. They meet each morning at 8:30 a.m. with the staff in a small crowded room for 1¼ hours. This is the community and is the essence of the hospital experience. Following this, the community breaks up into small groups for group psychotherapy with individual staff members. The afternoons are spent in workshops and the evenings in social gatherings. There is a well regulated program, and everyone knows where he is supposed to be at any given moment.

The Unit is largely experimental and application of its methods and principles is of considerable interest to us. There is a research team composed of social scientists. People here are enthusiastic about the Unit; but as you can imagine, the hospital Administrator tears his hair periodically when some of the more aggressive psychopaths tear the hospital apart.

I am coming to learn a great deal about group dynamics, social science, "social psychiatry". There is a place for the latter. They seem to have something here.

Recently, the Unit was visited by Dr. Maurice Schwartz and his wife. He is a sociologist who studied social forces and interpersonal relationships at Chestnut Lodge and published a book this year called "The Mental Hospital" in collaboration with A. L. Stanton. It is well worth reading. It discusses the interaction of the hospital and its staff on the perpetuation of illness due to covert disagreements, etc. I had several talks with the Schwartz's and also heard him address the section on Psychotherapy and Social Psychiatry at the Royal Medico-Psychological Association. It was a real opportunity for some new ideas.

Recently I visited the Netherne Hospital which is similar to Warlingham Park. I have not yet visited the latter because Dr. Rees is away at present. They are essentially similar hospitals except that the Superintendent of Netherne, Dr. R. K. Freudenberg, has retained one closed ward on the male side, and one on the female side. Otherwise, the hospital is open. It is an eye opener to see it and hard to imagine that such could occur. The hospital is fifty years old, built as a typical state hospital. There are no barred windows on any wards, even the acute disturbed. (There never were.) The hospital has taken down its iron fence and opened the locked doors. This occurred ten to fifteen years ago and happened over a period of many months. It was done by first attempting to meet the needs of the patients better so that they would be interested in the hospital, then they opened up, and no one has really become a problem in elopement. All forms of treatment are used. The Insulin Unit for deep coma is two doors inside the Admission Ward. There are no locked doors.

All first admissions go to a series of connected cottages. The admission section is the nicest of the hospital. If someone shows acutely disturbed behavior (catatonic, refusal to eat, etc.), he is given EST and Thorazine until manageable. Men and women are admitted to the same section and have many areas in common. Great stress is put on the therapeutic value of the hospital - group work, distribution and delegation of the authority of the staff, therapeutic community, group social activity, social clubs, etc. This is done not only for acute admissions of neurotic disturbances but also for psychotic disorders, both acute and chronic. On admission, the neurotics are put in a separate ward but it communicates by a corridor with the ward for psychotics. Psychotic patients have their own groups but not their own social club. Seniles are treated in the same way. They had about 500 senile patients, and I saw not more than ten in bed. Men and women mingle together here too. All is on the ground floor and open to beautiful gardens. There is an air of freshness and interest in things. The wards are simply but comfortably furnished. There are all wood floors, no odors; flower pots in even the disturbed wards and a real attempt to do away with institutional atmosphere. There are 400 nurses (always have been), very few aides (one nurse per five patients). Fewer nurses are required when the hospital is open because the patients do much of the work themselves. They are not required to do any menial work. Toilet rooms are clean, toilets encased. Effort apparently has been directed toward making the hospital as near hotel or home-like as possible.

They have an annual sports week for chronic patients where all of them get out each day and engage in various sports events. I watched hallucinating, deteriorated schizophrenics play games or watch other patients out in an open area. The nurses were around but dressed in street clothes (men), women in semi-nurse uniform (black stockings and small apron).

The Superintendent gave me these figures:

One Pound - $2.80

Cost to operate hospital per year L 400,000 to 500,000

Cost per patient per week L 5 1/3

Patients - 1,400 females, 500 males, 25% over 65

Admission rate 1,400 - 1,600 per year

Discharge rate 1,400 - 1,600 per year!

A five year study ending last year showed that of all patients admitted in that period, only 69 remained at the end of that time! Re-admission is more common for short periods because of easy acceptance of the hospital (and perhaps national health service). This, incidentally, is looked on with much more favor by most doctors I've talked to than is analysis. There is a staff of fourteen doctors. Eight have been analyzed. The hospital approach to patients is eclectic. They have a full time Sociologist. Research is social (Social determinants of aggressive behavior and its effect on the Staff and other patients presently being studied). They do not have facilities for basic organic research but are interested. The Superintendent feels that they are not curing schizophrenia but are making the patient more socially adaptable. He feels that the answer to the cause of schizophrenia will be multidimensional - psychophysiologic and that the best treatment will be a combination of physical methods in an environment geared to permit the patient to have as much of a sense of belonging as possible.

This is the first bit of information that I have been able to get to you. As time goes on I shall continue to report events as I see them or experience them. This is a very thrilling opportunity and gives one an excellent perspective of American psychiatry.

Most sincerely,

John A. Koltes, M. D.

Coulsdon, Surrey, England
August 6, 1955

Dear Dr. Davis:

Here is my second letter to you of our activities here. Things continue to move very rapidly and with great interest. This is a fascinating country, its institutions, people, ideals and way of living. Things are amazingly well organized in some ways and highly disorganized in others. Socially, the country seems well advanced although this may well be open to question according to one's ideals. By and large there is much less emphasis here on individuality and competition and more interest in cooperation, understanding and sharing. People still queue up for things, for example, not because there is a shortage but through habit. They wait patiently in line in stores or for the bus rather than crowding and pushing which is so characteristic of our experience in America. (I'm trying to portray my observations of the British scene - I've not been converted to any new major philosophic changes.)

Since last writing, I have visited Roffey Park Rehabilitation Unit (Dr. Ling & Dr. Davis), St. Thomas Hospital (Dr. Sargant & Dr. Shorvon), and Cane Hill Hospital (Dr. Walk & Dr. Charatan). I have also returned to Netherne Hospital for another look at their management of the acute admission service and treatment of the chronically ill.

Here is a brief breakdown of each hospital. (I have extensive notes on each place.)

1. Roffey Park Rehabilitation Unit - Located in Horsham, Sussex, 40 miles south of London. Started during war for treatment of industrial casualties (neurotic breakdowns). It has continued to do the same but now takes patients from everywhere under the National Health Service. The average length of patient stay is 6 to 10 weeks. All known forms of treatment for acute neurotic reactions are used. The most interesting part was the use of lysergic acid for abreaction and a large building given to an educational course for the instruction of captains of industry in the psychological problems of workers. I plan to return for another look in two weeks.

2. Cane Hill Hospital - This is a 2000 bed mental hospital in Coulsdon. I went to see it because it is a typical, average, orthodox British mental hospital. It is not unlike Byberry in that it takes patients from other hospitals but it also has an acute Admission Service. There are 12 doctors on the staff and one nurse per twelve patients; two Social Workers and one Psychologist enroute to the hospital. The hospital is 50% open - that is, about half of the wards are unlocked. As in the other hospital that I visited, patients are admitted to the best ward first. This seems terribly important to me, especially since my experience at other units where this is not true and where it causes trouble. There are 1000 admissions per year, somewhat fewer (800more or less) discharges. 25-30% of the patient population are senile; most are out of bed. (One hospital near London has 2000 seniles all over 70 years, nine doctors, 50% of the patients ambulatory.) In the treatment of the chronically ill, great stress is put on worthwhile employment within or on the hospital grounds rather than routine O. T. Cane Hill has two insulin units, one for men and one for women. They are enthusiastic about chlorpromazine, lukewarm about leucotomy. I saw one patient on the male side in a closed room, no others. There are no barred windows. They have rugs on floors in some wards, fresh paint, TV, pool tables in the wards and day rooms. The hospital was built in 1870 and served as a pattern for one of our State Hospitals, although the Superintendent did not remember which one it was. He will check his files and I shall inquire later.

3. Netherne Hospital - Returned here for a look at their methods of operation more accurately. The hospital serves a population of 600,000 and takes anyone. The Superintendent (R. K. Freudenberg) is socially conscious and open-minded on any techniques available (leucotomy to analysis). The hospital has more money than Cane Hill because it serves Surrey and is supported by that county while Cane Hill Hospital serves a tenement section of London. They don't mix patients although the hospitals are near each other. Doctors from both hospitals work in general hospital psychiatric clinics as part of their work. Patients are followed there in the O.P.D. if at all possible. This reduces cost (perhaps could be done in Reading, Pa., for example, if Fred could get a foot in). Here it is compulsory that general hospitals in areas served by a mental hospital have a psychiatric O.P.D. Netherne has a total push program for the chronic patients. They advocate gainful employment in hospital shops, farming, and a very progressive Admission Service. Most first admissions go to a separate group of cottages where they are given treatment appropriate for their illness, neurotic or psychotic. They are experimenting with doing away with standard committments for this unit, even including voluntary. A Royal Commission is studying this, and I hope to get a copy of the report. This still remains the most impressive State Mental Hospital that I have ever seen and feel that much of it is due to an enthusiastic, liberal, progressive, open-minded Medical Superintendent and staff. Here there is black, white and shades of gray in policy. The superintendent of this, as all British hospitals, must answer to a Hospital Management Committee who in turn is responsible to a Regional Medical Board. Both groups are composed of medical and lay people. The Regional Medical Board is responsible to the Ministry of Health. There is close organization. Everyone knows what everyone else is doing in a given area for the Superintendent of Belmont Hospital, for example, is on the Regional Medical Board which governs all the hospitals in this large district so that he is well acquainted with things at Netherne, Cane Hill, Banstead, Belmont, etc. This organization needs further understanding. I wonder if it may not play a role in Pennsylvania needs. It certainly serves a useful purpose here. I am not speaking for the National Health Service - that's an entirely different matter. What I have in mind is that people are aware of what is going on through their administrative organization which serves a very great purpose.

4. St. Thomas Hospital - I have had an opportunity to spend a good deal of time with Dr. William Sargant of St. Thomas. He is regarded as the outstanding authority in England on physical treatment in psychiatry. I'm certain you have heard of him or may know him. He is a fascinating person. His methods have an interesting origin - they started under the pressure of war when he worked at Belmont (Sutton Emergency) Hospital where they were swamped constantly with NP patients. He developed insulin subcoma treatment and very extensively used abreactive techniques. He is head of the department at St. Thomas Medical School and Hospital, has a resident program, a very large O.P.D., private and public beds, etc. He thinks of psychiatry in one way - "treatment - what are you doing for the patient". His O.P.D. is largely organic in treatment methods but they are highly organized and seemingly very effective. It is divided into two groups - abreactive and psychological. The latter consists of psychotherapy and some analysis by one staff analyst. The former is run by Dr. Shorvon who is considered to be an expert in the field. They use CO_2, ether, lysergic acid, barbiturates, methedrine for abreaction. They have a very extensive EST service and use "scoline" (acetylcholine) and pentothal routinely preshock - getting no major convulsions. They treat severe arthritics, etc. - I saw them. I saw a patient who had severe kleptomania and a tension state that had a leucotomy. Sargant is very enthusiastic about leucotomy. They had 16,000 clinic visits last year (I have a breakdown of the figures) seen by a staff of four or five doctors.

Again, organization did the trick, plus nurses (three in clinic) who were strategically placed. An anesthetist is present for all EST. They have very few fractures and apparently the abreactive treatment, including acetylcholine for obsessives, has been useful to them. The program is comprehensive and well led. This is another secret of their success. Also, they are willing to take a look at any kind of treatment, and if it is reasonable to them, they will try it. They are experimenters. They constantly talk about keeping the hospital population down. Sargant said Dr. Walter Freeman couldn't work in England as he does in the U. S. because hospitals don't have that many chronic cases who have had little care.

Lastly, I am still working with Max Jones and am beginning to feel a good understanding of the therapeutic community and its underlying dynamics. I hope to learn more of the feed back theory described by Norbert Wiener and see if I can make any correlations.

Max's community is limited to the treatment of psychopaths but the principles of doctor-patient relationship set down here can be applied in many circumstances. The development of social psychiatry is extensive here and the more progressive hospitals have applied some of the theories that he has developed and applied. Max spent several weeks with Bob Matthews in New Orleans last year at Charity Hospital. I read and abstracted the paper they wrote. What happened there could happen at Wernersville. Essentially, the ingredients are nothing more than changing the doctor-patient relationship so that the doctor exposes himself to the questions and interpretations by the patients of his behavior rather than hiding behind a wall of authority. Breaking down these barriers gives the patient a better status and <u>much</u> more interest in the hospital for he plays a role in saying what is going on rather than being totally dependent on the hospital for treatment. The feed-back concept comes in in Jones' Community wherein there are no privileged communications between patient and patient or patient and doctor. All report to the community, e.g. feed-back to the community what is occurring. This has many important significances theoretically and is particularly interesting in the study of communication. Naturally, this technique must be modified for psychotics; nonetheless, a major improvement could be effected by improving the doctor-patient relationship, developing a patient sponsored activity program, a program for active useful employment and participation of the physicians in local community affairs.

This is the essence of what is happening at Warlingham Park, Netherne, and other hospitals. Cuffs and straps are unheard of here. But in fairness to our own system - Warlingham Park has all open wards but is surrounded by a fence and gate keeper. Netherne has no fence or gate but keeps two locked wards. This seems better to me.

I have appointments for Warlingham Park, Guys Hospital (Dr. Stafford-Clark), Maudsley and Bethlem Royal Hospital (Prof. Aubrey Lewis), and the Tavistock Clinic (Dr. Thomas Main). I'm looking carefully at the resident training programs, the effects of the National Health Service, and the use of new methods of treatment here. I shall report on these other hospitals in the near future. I'm becoming chock full of ideas for the development of our system.

Cordially,

John A. Koltes, M. D.

Coulsdon, Surrey, England
August 11, 1955

Dear Dr. Davis:

May I send you a word you may be looking for - a bird's eye view of Warlingham Park Hospital. I was there this week, am returning tomorrow. But I wanted to get word off to you soon for Dr. T. P. Rees is planning to go to Boston for a conference in December on hospital personnel and he indicated an interest in our hospital and in Philadelphia. I feel rather certain from our talks that he would welcome an invitation to visit Philadelphia and have a look about. Perhaps he could speak to the Philadelphia Psychiatric Society or at one of the medical schools, or to a group of Superintendents from the various State Hospitals.

The success of Warlingham Park Hospital lies in three facts as I could gather. Firstly, Dr. Rees; secondly, its method of drawing patients; and thirdly, the active use of doctors in the community.

Dr. Rees is a fascinating person, a man of 55 (more or less) who has full control of the situation and is well acquainted with local, national, and international psychiatry. He was very courteous to me, spent the entire day and early evening with me showing me many of his facilities and discussing the philosophy of resident training, the method of procuring and keeping physicians in a state system and the question of running an open hospital. Briefly, he feels that a hospital system in the U.S.A. (compared with the British system) must compete favorably financially with private practice, and give the physicians an incentive to work towards a goal and a sense of satisfaction. This sounds somewhat trite, perhaps, but certainly the staff of his hospital is working in a much more intellectually stimulating environment than the routine mental hospital.

The hospital is a thousand bed hospital in Surrey serving only the city of Croydon, a town of 300,000 people south of London. It takes people from no other area and before the National Health Service, it was paid for by the people of Croydon. Dr. Rees has always been active in the political turnings of Croydon, not actively as a participant, but as a person "behind the scenes" getting money for the hospital by trying to make the people proud of the hospital. He feels strongly that a mental hospital should be responsible to a confined area and that the people in that area should be responsible for the success or failure of their hospital.

Since the hospital is responsible to Croydon, it supplies the city with outpatient facilities and treatment <u>in the town</u>. The staff, including Dr. Rees, spend 49 half days per week running O. P. D. psychotherapy, EST, child guidance, etc. The vast majority of patients admitted to the hospital are referred from the clinic. They are returned to the clinic on discharge. Essentially, there are no other psychiatric facilities in this city of 300,000.

The hospital is entirely open compared with Netherne which has two closed wards. People are free to come and go but there is a gate through which they must have a pass to get by. There are no high iron fences, but a four foot mesh screen along the front. The hospital is divided into sections. It was built about 50 to 75 years ago. The first ward was unlocked in 1936, the last in November, 1954. There is an admission building for men and one for women. Each contains an insulin unit of about ten beds for coma therapy by Sakel methods. But the patients also use the same beds to sleep in at night and do heavy work (mopping, gardening) after treatment. All patients are initially admitted here, then transferred to the main buildings unless they are on insulin.

The buildings are fully open and right along the road. The main hospital contains wards for chronic patients, seniles, and an alcoholic ward. The latter is very comfortable. Group therapy is the method of treatment there. A patient from this ward escorted me about the hospital as is done with all visitors. In addition to these units, the isolation building formerly used for fever cases now is used for ten men and ten women neurotics mostly of passive, inadequate type who are hospitalized here where they live together except for sleeping, prepare their own food, hold group therapy sessions, and do all their own chores. They stay for eight weeks only, no more or less, and cannot return. Dr. Rees says there have been no disturbances or pregnancies. A nurse is there but no M.D. except for a daily one hour group session. There is also a 45 bed unit on a magnificent estate near Churchill's home in Kent used for ambulatory seniles. A nursing sister operates it with an M.D. who comes only on call. The alcoholics have close contact with Alcoholics Anonymous. Patients are given a brochure and hospital description on admission. Every attempt is made to make them feel at home. One takes care of another. There is one ward of chronic schizophrenic patients run entirely by themselves. Dr. Rees feels that too many nurses get in the way but this to me seems disputable. The wards are all locked at night but the key is left in the door for fire reasons. One nurse covers two wards.

The O.T. Shop is unique - it mixes refractory women with "good" men and vice versa which apparently has been very helpful to the sicker group. A shop of 35 patients was run by one person!

The hospital grounds are beautiful. This is characteristic of English mental hospitals and the patients take delight in raising flowers for an annual competition with other hospitals. They also meet weekly with the Chief Chef, one patient from each ward, and discuss food problems. I sat in on this, and it was fascinating. Most of the criticism was constructive and imaginative although of the ten people there, at least half were obviously very ill merely from their appearance and tones of voice. This to me is the encouraging aspect of my experience here and I certainly earnestly hope that we can put some of this into action.

It would seem unlikely that we could achieve anything like this immediately but we certainly could get started very soon. One cannot just open the doors and expect results. It takes planning and cooperation of the <u>entire staff</u> - doctors, nurses, gardeners, maintenance crew, O.T. department, etc., and patients. All must function together as a team with the goal of getting well and leaving the hospital ever present. Warlingham admits about 800 per year and discharges about 740; others die or are transferred. We ought to be able to match this eventually.

Both Dr. Rees and Dr. Freudenberg point out that the place to begin is by giving the patient the idea that he is worthwhile and that there is something worthwhile for him to do. Don't let him get lost in a shuffle of thousands of patients. Don't build hospitals over 1000 beds; 500 is better. Keep the area which the hospital serves small and well defined. Let the community have a share in the operation of the hospital and make them responsible for it. Give the staff the freedom required for their own emotional growth; don't nurse them and make them dependent on a system. Encourage them to live out of the hospital (I suggested to Dr. Appel many months ago that state hospitals might be a group practice). These undoubtedly are the rules which are used to operate the Warlingham Park and Netherne Hospital, and they are by far the most progressive, best treatment hospitals that I have encountered.

Next week I shall have a report on the Maudsley Hospital (the Post-Graduate Institute of the University of London) and the Tavistock Clinic. The former is exactly the same as Eastern Psychiatric, the latter a clinic for psychotherapy applied with Anna Freud and Melanie Kline.

Cordially,

John A. Koltes, M. D.

Coulsdon, Surrey, England
August 28, 1955

Dear Dr. Davis:

We are still in the London area although this week are scheduled to leave our house and move into downtown London. I will be there for several days to take a final look at the London teaching hospitals, of which there are twelve.

I have spent the past week at the Maudsley Hospital. It is a graduate school only and has an enormous training and research program. It is the largest hospital in Europe, especially for the training of psychiatrists. There is a resident group of between 50 and 60 every year. The staff is quite large and represents every phase of neurology and psychiatry. Prof. Aubrey Lewis is the head of the hospital.

Each department is a unit unto itself (Chemistry, Neurosurgery, Out-Patients, etc.) and communication is somewhat of a problem. The hospital is important only insofar as it provides a place for highly trained specialists to work. This I do not say critically but factually because it is a problem to the people working there. They do a tremendous amount of original research every year which is published in many different places and is not collected in one volume for general publication. Prof. Lewis does not approve of this. It is entirely an eclectic hospital with representation from every branch of psychiatry. Undoubtedly, our hospital will be much like it in design and purpose but I would hope to improve the communication methods so that the hospital functions as a unit rather than as a group of individuals.

I had a very long talk with Prof. Lewis (people tell me that is exceptional) about the training of psychiatrists and with Mr. Johnson who is lay director of the hospital. I have a paper written by Prof. Lewis on the subject which is well worth reading and is a general philosophic eclectic approach to the problem. Mr. Johnson acts as administrative director and he is entirely responsible for the operation of the hospital and to the management committee. We discussed the use of administrators in hospitals to do the non-medical work of superintendents and we concluded that: 1) His job was very important; 2) He was very helpful to the medical staff; 3) No administrator could start to work in a hospital where the superintendent was well established except by the superintendent's request; and 4) When a new superintendent takes over a hospital, an administrator might start with him then. In England, medical superintendents who devote full time to hospital administration and do no clinical work receive administrators' pay which is less.

I have seen the Day Hospital at Maudsley. Dr. Arthur Harris, the director, tells me that Trenton State has one. This seems to me to be an excellent idea. Certainly, I should think that it could be used in some of our hospitals - perhaps for seniles and less severe psychotics who could sleep at home and spent the day at the hospital. Here they admit only patients sick enough for hospitalization. Most are referred from the O.P.D. All forms of treatment are used except deep insulin. Patients stay four to six weeks and are then followed as out-patients.

Maudsley, like other hospitals here, is using lysergic acid treatment for abreactions - much like CO_2, ether, and pentothal. They also are using methedrine, and acetylcholine abreactions with good results. To my knowledge, no one in the U.S.A. is using lysergic acid for anything but experimentation. They have used it here on hundreds of clinical cases - Davis at Roffey Park, Sargant at St. Thomas, and Leigh at Maudsley.

I have been to Tavistock Clinic, a psychotherapeutic out-patient clinic in London. Although eclectic, it is decidedly analytic in orientation. Their Institute of Social Relations is allied with the Ann Arbor group. Most of the monographs are on industrial studies (industry supports the Institute - they are not National Health Service). Guys Hospital is one of the London teaching hospitals. It has a 45 in-patient bed unit in one building. It corresponds to Jefferson, Temple, etc., being a general medical and surgical teaching hospital. Dr. David Stafford-Clark is department head. The under-graduate teaching programs generally do not seem to be as inclusive or as intense as ours although all of the hospitals have psychiatric beds.

Bethlem Royal (old Bedlam) is a beautiful hospital in the London suburbs, built in 1930. It has 250 beds, some open and some closed, with all forms of treatment. Again it is the typical British unit with no barred windows, flowers and rugs in the wards, ample gardens for the patients, etc. We ought to be able to do something like that. People tell me it takes several years to unlock wards. Staffs often oppose it, especially the older members, and one must wait for them to retire. Netherne Hospital has been opening since 1946 and Warlingham since 1936. But we could certainly get started doing something. Everyone says 1000 beds is top size. It has made me wonder about the new hospital going up in Delaware County and Byberry. Would they function better if there were two hospitals with men and women on both sides in a more normal homelike atmosphere? I don't agree with custodial care plans and plants - there is too much evidence that an active program moves people out of the hospital.

I have set up a trip to Scandinavia - Oslo to visit some of the people trained by Max Jones, Stockholm to visit the Karolinska Institute, and Copenhagen to visit the people doing genetic research. Copenhagen is said to have the finest forensic psychiatry in the world plus an ambitious program for prisions (other than castration!) They also have an index of every admission to every hospital in the country. No wonder they are genetically minded.

Cordially,

John A. Koltes, M. D.

Coulsdon, Surrey, England
September 5, 1955

Dear Dr. Davis:

Many thanks for your good letter. It was heartening to hear that you were pleased with my reports. I have tried to keep you posted on things as they have happened here and as I can interpret the feelings and the unspoken occurences and events.

Sincelast reporting to you, I have continued at the Maudsley Hospital making rounds with some of the other Chiefs of Service. The first part of the week I spent with Dr. Dennis Hill and Mr. Murray Falconer. The former is Chairman of the Department of Psychiatry at Kings College Hospital, London, and Director of the Department of Neurophysiology (EEG) at the Maudsley Hospital. Mr. Falconer is Chief, Department of Neurosurgery at Maudsley. Dr. Hill is regarded as the outstanding electroencephalographer in England. He does all of the EEG's for Maudsley and also runs the Epilepsy Clinic. He is a psychiatrist at Kings Hospital and Neurophysiologist at Maudsley - a fascinating combination. He is a remarkably astute man and one worthy of the reputation which he enjoys.

At present, the EEG Department is concerned with the problem of temporal lobe epilepsy and they have been doing sphenoidal lead tracings which pick up temporal lobe discharges beautifully. Apparently, only a few places use this technique. It is done by inserting a 22 or 23 gauge needle about 1½" long through the mandibular notch up to (but not through) the foramen ovale. They do the tracing bilaterally without anesthesia.

Mr. Murray Falconer (in southern England, all surgeons are addressed as mister) is excising temporal lobes in cases of epilepsy due to lesions of that lobe. They have done between 50 and 60 with good results. One patient had a bilateral lobectomy but died. Apparently, they have found all sorts of unusual things micrscopically, particularly tumors that were not suspected clinically. I read the case report of one 22 year old girl that had been severally epileptic for many years (since age 8 when she had whooping cough) and who from age 15 became markedly introverted. At 20, she was clinically diagnosed as schizophrenia and was very ill with hallucinations in all spheres, paranoid delusions, and some behavior disturbance.

She had an EEG which showed evidence of diffuse cortical disturbance and a suggestion of some localization in one of the temporal lobes. Sphenoidal leads studies showed temporal lobe damage, and she was operated on in October, 1953. She had a stormy post-operative course with marked hallucinosis and several fits but things gradually settled down and for the past 18 months, she has been working regularly. The diagnosis of temporal lobe epilepsy is made by the nature of the aura. Mr. Falconer removes about 7 cm. of the lobe including most of the medial structure by gross dissection. I understand that Penfield in Montreal does the same operation but not as extensive a dissection.

I visited an "Observation Ward" with Dr. Stengel (a personal friend of Dr. E. A. Spiegel at Temple University). It is an 80 bed unit in a general hospital, one of several in the London area, where patients with psychiatric illnesses are admitted for a period of not more than two weeks. If they do not recover within that period, they may be transferred to a mental hospital. There is not much treatment here. The orientation is primarily investigation. In this particular one, the medical staff comes from Maudsley, the nurses from St. Francis Hospital. The wards are all closed and the

patients are under temporary care papers. The advantage is that there are always psychiatric beds available in the city for acute emergency admissions. This is a real asset and terribly important. The chief objection to this service seems to come from the mental hospitals (none of which are in downtown London) who say that they miss the first two weeks of the patient's illness and have to overcome this problem when the patient is transferred. Of course, if the patient recovers in two weeks (and many do) they are followed in one of the city Out-Patient Departments, as indicated.

One day I went to a local hospital (the Banstead Hospital in Sutton) with Dr. Morris Carstairs who is running a pilot study on employment of chronic hospitalized schizophrenics. He has set up an experimental unit financed by the State Research Council consisting of a group of rooms in which patients work. At the present time, all of the patients are men (about 20) and they fold and pack boxes. The work is subcontracted and they are paid piece-work, up to about $3.00 per week. It is entirely an incentive program designed to relieve "backward" living and convert useless time into productive time. This is more than "good O.T." The patients are doing this work for pay with a definite goal - money, a chance to work, and possible discharge. Eventually it is planned to employ as many people as possible and to develop a "Re-Employ Factory" in the catchment area the hospital serves. This would be a factory for the disabled where they are paid for their work and which is under hospital supervision. The work is useful but not competitive with the open labor market.

A hostel is also planned where ex-patients may live. It also can be used as a Day Hospital. In other words, this again is an example of ingenuous planning using very few materials at a very low cost; give the patients useful work to do, pay them a small incentive wage if they work, move them out of a hospital into a hostel as soon as possible. Someone has said that hospital patients make very poor workers but I wonder how many hospitals give patients incentive to work other than an opportunity to get out of a stuffy, over-crowded ward.

Carstairs has studied the learning curve of chronic schizophrenics on a device of his design where they sorted buttons. Nurses were used as controls. It was found that the chronic schizophrenic tends to learn more slowly as would be expected and that it varied with various kinds of schizophrenia, length of hospitalization, etc. This is an excellent program and is not unlike one in Holland and Paul Sividon's in Paris which will be reported next month. Again, I feel that we have the potentiality to develop something like this. Here's a man who could keep at least 200 patients busy doing productive work and he would need very little help because the patients are interested. This also has been demonstrated at the Manor Hospital for Defectives where they have imbeciles doing similar work. As a matter of fact, Dr. Carstairs' idea is an outgrowth of that experience.

I was glad to hear that you will invite Dr. Rees to Philadelphia. You will find him to be an extraordinary person of great capacity and with wide knowledge of psychiatry. He will give some interesting material for you, I'm certain. I've been back to Warlingham Park again and spent a good deal of time with some of the staff and some of the nurses. After all, they are the people in daily touch with the patients and have the intimate contacts which are so vital to good hospital functioning.

Of the nurses that I spoke to, none would prefer to have the hospital closed but all would prefer more help. They feel that ideally there should be one nurse for every 8 to 10 patients. Incidentally, nurses here are different than in the U. S. Mental hospital nurses are called R.M.N. - Registered Mental Nurse and are graduates of an approved mental hospital nursing school, a three year course. The S.R.N. - State

Registered Nurse, is a graduate of a general hospital nursing school. They are not interchangeable. It seems to me that this is generally a good plan because mental nursing is so much different than general nursing.

One final word - I spent some time with Prof. Hans. J. Eysenck who is head of the Department of Psychology of Maudsley and one of the professors of Psychology at London University. He has a very extensive department which is almost entirely experimental. The orientation is basically experimental rather than clinical in direction. For example, no projective tests including TAT or Rorschach are used because they feel that these cannot be validated experimentally, hence are not scientific. This surprised me but it is so. Eysenck is a brilliant German who has had an exchange Professorship at Penn. He feels that anxiety is constitutionally determined and he has written extensively on his theories of personality (which are somewhat heavy reading but highly interesting).

The end of this week finds us leaving the London area for Scotland. I have arranged meetings at Edinburgh with Prof. Kennedy who is taking over from Sir David Henderson of (Henderson and Gillespie), and Dr. Thomas A. H. Munro who is superintendent of the Royal Edinburgh Mental Hospital. I also hope to get to Creighton Royal which is said to be one of the finest mental hospitals in Scotland. From there, we venture on to Oslo and Stockholm. The people to whom I have written in advance for arrangements to visit their clinics have been very helpful and well accepting of us. We continue to be delighted with our experiences and ever growing knowledge. I have accumulated over ten pounds of reprints to date!

Most sincerely,

John A. Koltes, M. D.

Edinburgh, Scotland
September 13, 1955

Dear Dr. Davis:

I wanted to send you these two articles on open mental hospitals because of their interest and direct applicability to our program. You are generally familiar with the Warlingham Park program - a 1000 bed mental hospital serving the city of Croydon, staff of twelve physicians, no closed doors, all types of patients admitted.

Today I visited another pioneer in social psychiatry, Dr. George Mac D. Bell at his hospital in Melrose, Scotland. We came up to Edinburgh this past weekend and the following appointments have been arranged - Dr. Hugh Craigie, Chairman, Board of Control, (somewhat similar but "higher up" than our Commissioner of Mental Health - he is a grand person and was very helpful to me in arranging appointments), Dr. Bell, Dr. McCowan at the Crichton Royal Hospital (said to be one of the best in all Britain), Professor Kennedy (University of Edinburgh), Dr. T.A.H. Munro (Royal Edinburgh Mental Hospital, a department of the University), Professor Ferguson Roger, University of Glasgow (who is going to address the Royal Medico-Psychological Association this week on Russian psychiatry to which I have been invited as a guest of Dr. Craigie). As you can see, this is a very full schedule but I have tried to crowd as much into our stay in Scotland as was possible.

Dr. Bell's hospital, The Dingleton Hospital, is located in the town of Melrose 40 miles south of Edinburgh in the mountains of Midlothian. It is a small hospital, 418 beds, originally built in 1868 for the mentally ill. It is a two story, grey stone structure, has lovely gardens and pleasant surroundings. Melrose is a small town completely rural; the main industry is a woolen mill and sheep raising. Of aesthetic interest is the Melrose Abbey on the edge of town, an ancient structure partially destroyed in the Scottish-English wars. I was greeted by Dr. Bell in person and after tea was shown the hospital accompanied by the matron (chief nurse). At present they are remodeling, applying some optomistic pinks and greens over pessimistic browns and grays. There were no locked doors, no padded rooms, no restraints. Patients are entirely free to come and go. Unlike Warlingham, there is no guard at the gate. 80-85% of the patients are voluntary. There were 360 admissions last year and 500 more or less out-patient visits. There are four physicians and a nurse-patient ratio of 1:8. Dr. Bell maintains that agitated patients are the <u>easiest</u> to handle because there is much less for them to be agitated about. Escape, etc., is an incidental problem. The rate of epileptic fits is much reduced as he notes in his paper, "A Mental Hospital with Open Doors." Also, unlike Warlingham, there is no active work program as a substitute for closed doors. The patients have an active social program as does the hospital staff (all the nurses, the domestics, etc.) together. The hospital still operates under the old commitment laws although with open doors, the significance of commitment changes considerably. The Dingleton Hospital has been an open hospital a great deal longer than Warlingham Park and both superintendents are enthusiastic about the scheme with equal intensity.

Scotland has a boarding-out system for chronic psychotics and mental defectives. About 4000 patients in these groups are housed in private homes throughout the country and in the surrounding islands. The state pays for their keep. All are committed (certified). The program has existed for <u>100</u> years and is operated by the Board of Control, local physicians and social workers. A member of the Board (there are four altogether) visits every psychotic once per year and every mental defective twice yearly. There is nothing in writing about this program that I can find at the moment but the Board is sending me reprint of a report on it in the near future. More of the

boarded out patients are defectives than psychotics - about three to one. There are 20,000 beds for mental patients in hospitals and 6,000 beds for defectives. The country is very friendly but also intensely nationalistic and individualistic.

Before leaving England, I saw Dr. J. R. Rees of the World Federation of Mental Health and I visited the office of Dr. the Honorable Walter S. Maclay who is chairman of the Board of Control. The latter was away but I spoke with his associate and obtained some literature which gives a bird's eye view of the organization of English psychiatry under the National Health Service. You must know J. R. Rees and the Federation. He is a tremendous person and was most kind to me in making suggestions of people to see.

Also before leaving I arranged with Max Jones to write a paper on the Social Rehabilitation Unit and outlined a paper on comparative studies of English and American psychiatry. I hope to have the first paper well under way by the time I get back. It will be a joint authorship. The second paper will be a great deal longer in process and only a rough outline is possible at this time. The purpose of it would be to highlight the effective methods of treatment in both systems and to promote a better understanding of psychiatric practice in the two countries. There are a few basic differences - the most obvious being: 1) Most psychiatrists are employed by, work in, or are otherwise associated with a hospital and 2) Psychoanalysis is just another method of treatment in selected cases, nothing more.

From my knowledge of psychiatry at home and abroad, I would say that our situation tends to be the opposite - most psychiatrists are in private practice or part-time hospital work and analysis plays a much more important role. It is interesting to note that many of the leaders of psychiatry in America today are men who came to Europe during the 1920's and 1930's and were analyzed. Men coming to Europe today either spend full time in an analytic setting like the Jung Institute in Zurich or the London Psychoanalytic Institute or they participate in the programs of social psychiatry which are much more popular, more common, and more widespread. Looking at England and Europe from here, I would guess that most psychiatrists are not working in the direction of analysis but rather toward programs of treatment which reach more people. There aren't enough patients who can afford analysis to support a large number of analysts.

It is not uncommon to hear the criticism of American psychiatrists that they are in private practice and especially analytic work because it is lucrative, that American psychiatrists are serving the dollar, not the profession, and that if economic circumstances were less favorable, there would be less analysis. These criticisms come from thinking people, practicing psychiatrists, all of whom have visited America, one of whom is an analyst working in a teaching hospital.

From Scotland, we sail for Norway where I plan to spend a few days with a group of physicians trained by Max Jones. Then on to Sweden (Stockholm) to see Professor Sjorgren at the Karolinska Institute. Sweden is said to have the most beautiful and most modern hospitals in the world. From one of the physicians at the Maudsley Hospital I got a paper that he had written on Scandinavian psychiatry which was very useful in planning our trip. I have received a welcoming letter from Professor Querido in Amsterdam and Professor Bleuler in Zurich. It is very stimulating to be so well received and given so much attention. Everywhere I find considerable interest in our new hospital and well wishes for its success. I have become more and more impressed with "social psychiatry" - a refreshingly new approach to old problems. It seems to be basically little more than a common sense, forthright approach to the problem of mental illness, taking the fear out of it and treating the patients like human beings.

If we can do that, we will have come a long way and I would personally be very much in favor of a department of social psychiatry at the Institute where some of these methods can be proselytized and new methods tried out.

I shall try to get a note off to you again in the near future reporting on the Crichton Royal, the University of Edinburgh, and the University of Glasgow.

With all good wishes,

John A. Koltes, M. D.

P.S. May I apologize for having to send these reports to you handwritten. We are toting over 200 lbs. of luggage and at times I feel a bit more like a mule than a human. To get things typed at just the time one wishes is difficult to arrange.

Edinburgh, Scotland
September 14, 1955

Dear Dr. Davis:

I am sending along by regular mail two articles on the "open hospital" together with a letter of explanation of our activities to date. One article is from Warlingham Park, the other from the Dingleton Hospital in Melrose, Scotland.

I spent the day at the Crichton Royal Hospital in Dumfries, Scotland. It is a magnificent place in southwest Scotland, in the home town of Robert Burns. It is a 1,300 bed hospital on an estate of 1000 acres beautifully planned on a cottage or villa system. It is 50% open. The first superintendent, Dr. Brown, wrote at length 115 years ago about open doors, active physical programs, group psychotherapy, and analysis of dreams! One of the staff members is studying his writings which were never published (except in annual reports) and is considering a biography. It would be a real asset to us, especially when we talk about "major advance in psychiatry like group therapy and open doors". I obtained a review of some of this writing - it is fascinating reading.

Dr. Mayer- Gross was the Clinical Research Director at Crichton Royal until this year when he retired. He is considered a very important figure in European psychiatry and was one of the professors of psychiatry at the University of Heidelberg until the war. He is an expert in insulin therapy and schizophrenia and last year published a very thick germanic textbook "Clinical Psychiatry" with Eliot Slater of National Hospital Queens Square, London, which is well worth looking over.

Cordially,

John A. Koltes, M. D.

Edinburgh, Scotland
September 18, 1955

Dear Dr. Davis:

We have completed our stay in Britain and are moving on to Scandinavia tomorrow - Oslo, Stockholm, and Copenhagen. Before leaving here, however, I wanted to send you a resume of psychiatry in Britain as I have observed it and worked in it during the last many weeks.

First, I have tried to look at British psychiatry objectively and to extract from it those things which would seem to be most useful in teaching and in practcal application for us in the State Program. Before going into this, may I complete my report on psychiatry in Scotland to bring you up to date.

A report has been sent on about the Dingleton Hospital which has been an "open" hospital for a number of years. Subsequent to visiting that hospital, I spent a day at the Crichton Royal Hospital in Dumfries. It is a magnificent institution, formerly private, now National Health Service sponsored. It has 1,300 beds, 1000 acres of grounds, an enormous building containing a very large gymnasium, swimming pool, OT shops, physio-therapy and large library. It is one of the most beautiful hospitals that I have ever visited and looks much more like a college campus than a hospital. It is built on the cottage plan; there are no large "institution-like" buildings. None are over two stories. About half of the hospital is unlocked. They have a vast research department, the best in Scotland. Professor Meyer-Gross headed it until his retirement last year. Their work is primarily in chemical research - antihallucinogens, chlorpromazine-reserpine trials and a large EEG laboratory where they are trying to correlate personality types and EEG patterns. They build all of their own equipment. There are sixteen full time physicians and a large nursing staff. The chief nurse, Miss Haulistan, impressed me as being a very capable woman, one who has written widely, travelled extensively, and is socially very charming. She visited Byberry in 1948.

Following this visit, I had a long session with Professor Alexander Kennedy who is the new professor of psychological medicine at the University of Edinburgh. He is a grand person, very easy to know, is extremely energetic and has a wealth of enthusiasm. His orientation is primarily Meyerian and he plans to continue his resident training program along these lines. Although not anti-analytic, he feels that it does not have the things to offer which interest him. He is quite representative of British psychiatrists.

The University has a 1200 bed mental hospital associated with it which also has a new superintendent. This is the place I mentioned some time ago that I had heard about at the Maudsley Hospital where the new superintendent brought a lawyer with him to act as the administrator of the hospital. The superintendent plans to develop the clinical side and leave administrative matters to one trained along those lines. He, however, retains authority although it is divided by mutual agreement. At the Maudsley Hospital, the lay administrator is the nominal head of the hospital and he is responsible to the hospital board for the operation of the hospital. It is expected in Edinburgh that better clinical services will be available when the superintendent does not have the responsibility of non-clinical problems. It also dilutes the authority and acts against the formation of a kingdom within a hospital. They have the plan underway here and we can keep an eye on it through correspondence and see that develop. Dr. T. A. H. Munro is the Superintendent, and he is a fine chap.

It was my pleasure to be invited by the Chief Medical Officer of the Board of Control, Dr. Hugh Craigie, to attend the quarterly meeting of the Scottish Division of the Royal Medico-Psychological Association. This association corresponds to our A.P.A. The Board of Control is national and corresponds roughly to Commissioner of Mental Health of a state. It was a thrilling series of meetings for I had the opportunity of meeting most of the important men in Scottish psychiatry and to attend their scientific meetings. They discussed the problem of commitment and I hope to get a report of their considerations. Briefly, the whole thing is in a state of flux because their laws are over 100 years old although practically identical with ours; when changed there will be new provisions for the mental defective, the psychopath and the voluntary patient. The main address was given by Professor Ferguson Roger, head of the Department of Psychological Medicine at Glasgow University on his recent visit to Russia. He gave a full, objective, illustrated report on Russian psychiatry as accurately as he could gather it. Apparently, all of their psychiatry continues to be Pavlovian without any major changes since Pavlov's death.

It is interesting to note this since in perspective, one might say that Russian psychiatry was Pavlovian, British psychiatry Meyerian and American psychiatry Freudian. The British are particularly keen to note that the majority of their psychiatry is Meyerian and ours Freudian. They are somewhat critical of us, feeling that we have become too much one-sided in this regard. This perhaps is worthy of consideration when one realizes that deep insulin, modified insulin, chlorpromazine, antabuse, electroshock, lobotomy and indeed psychoanalysis are all European in origin. There would be little left if we had none of these.

I would say broadly speaking that the British hospitals are not as good as our best nor as bad as our worst. They come somewhere near the middle. I think that they are more humane in design - no window bars on any except for the criminally insane (all windows are blocked up to 6"), hardwood floors, flowers about, TV unscreened even in refractory wards, beautiful gardens, reasonable accessibility to a town by and large. Understaffing is not such a problem and is even less so since the National Health Service. Generally, I never in the weeks here heard one psychiatrist complain about the National Health Service. It has tended to improve psychiatry, giving hospitals and physicians more money than before. Private practice never was a big thing because the population cannot support it. With merit awards, one can make the equivalent of 20 to $30,000. Beyond that, taxes are so high that additional income is useless. It is also possible to have a private practice if one wishes. Also, some hospitals admit private patients and charge accordingly. At the Crichton Royal, for example, there are free beds and private beds, the latter costing the maximum of L 7 per week ($19.60). At the Edinburgh Royal Mental Hospital, they can charge up to L 22 per week ($61.60).

Hospitals are administered by two groups, the individual hospital board (of laymen) and a Regional Hospital Board (of physicians and lay people). The hospital board is responsible to the Regional Board and the Regional Board to the Ministry of Health. The latter is quite large, covering a wide area and several hospitals, and is composed of interested lay people and physicians elected from various hospitals. In this way, Dr. A. knows what is going on in Dr. B's hospital through the Regional Board. There is also a medical advisory committee which advises the Regional Board. (It is possible to get - and I have - a detailed description of how they are set up.) Our society is differently geared than British society and it is hard to envisage a National Health Service working as theirs does. But I wonder if we couldn't extract some things from their organization in the state service which would be beneficial. I am impressed with the tightness of the organization yet the ability to move within

it. Perhaps we could have a series of "Regional Boards" for the state hospitals which would act for the benefit of the group and lend itself to more sharing rather than isolation.

We need to improve our rehabilitation scheme. We are lagging far behind the British in this. They have many services available to help the disabled. There is a national saying, not a slogan, referring to "keeping fit"; another very common saying one hears is "so and so's ability to cope". There is no apparent desire to be dependent and taken care of in the national character; on the other hand, many services have been developed to help the fellow in trouble, physical or mental, dating back to the early 1900's. The disabled are well taken care of and not interfered with. As I illustrated in an earlier letter, for example, the people at the hospital for mental defectives (Manor Hospital) and Morris Carstairs at the Banstead Hospital are actually employing patients to perform useful work and paying them for it according to their productivity. Actually, this is nothing new. I obtained a paper abstracting a book written in 1855 by the first superintendent of the Crichton Royal, W.A.F. Browne, who in "Asylums What They Are and Ought To Be" stressed the importance of useful employment of patients, no large dormitories, and startingly the importance of group psychotherapy and dream analysis!

Since I've been here, I've wondered just how many of our hospital problems are iatrogenic. I look at the local policeman, he's a friendly chap with a funny Indian-style helmet. He is unarmed, unable to hurt anyone yet his authority is unquestioned and he preserves the law. True, they do not have as many drunks about the streets and as many automobiles but they have just as many people to work with per man. And maybe this is what happens in our hospitals. We build high fences and grill the windows so that no one can get out, then spend much time trying to quell the anxiety stimulated by a prisonlike environment. People here have tended to demonstrate that it's not necessary to be so on guard "against" the patient and that patients can be trusted far more than we give them credit for. Perhaps what is said here has some truth - institutions are often built more for the comfort of the staff than of the patient. Our own anxieties need to be coped with just as much as those of the patient.

There is a close association here between the teaching hospitals and the mental hospitals. Either the staff of the mental hospital teaches at the medical school or a member of the medical faculty consults at the mental hospital. There is good liaison. Dr. Sargant from St. Thomas Medical School Hospital, for example, spends one day per week at the Belmont Hospital for which he is paid a consultant's fee. His service at the hospital is an invaluable aid to the resident training program there and he can use it to refer patients from his private consulting rooms if he wishes. As a result, both hospital and consultant benefit by the arrangement.

Maxwell Jones' work in the Social Rehabilitation Unit has added a great deal to the knowledge of treatment of psychopaths. He also has done a great deal to investigate the doctor-patient relationship, and, for me, has stimulated a new interest in the problems of communication in psychiatry. He has shown the damaging effects of physician authority and the beneficial effects of enhancing the status of the patient within the hospital by group living methods. I have started a paper in joint authorship with him to report this work. Of course, there are a tremendous number of possible applications in our hospitals, particularly those that are in an area serving a fairly homogenous social group. Group psychotherapy, psychodrama, ex-patients club, patients' sponsored social activities, useful employment, day treatment center employment of the staff in the community OPD, and so on all are related to this work.

If we could get a pilot study going by raising some interest in the staff of one of our hospitals, we could demonstrate to other states: 1) That we are moving ahead with new things in psychiatry; 2) We are treating patients. It takes a young, flexible staff to do it or a superintendent who has the full cooperation of his staff. If we could do this in the hospital we spoke of, I'll bet that the local psychiatrists in the town would come in on the scheme. After all, a hospital of 2000 beds supported by the state ought to be an asset to a community. I somehow feel that good public relations would go a long way toward making it a community program. How about starting "Operation Community Co-operation"?

Lastly is the Royal Commission on Mental Illness and Mental Deficiency. It is a group of distinguished physicians and barristers studying these two subjects over an extended period of time and hearing witnesses from many quarters. Reports of the proceedings are published periodically. I do not know if such exists in Pennsylvania. Perhaps we could have such an organization sit once every five or ten years to report on the over-all state of the mental health of the people of Pennsylvania and to report on new findings and progress in psychiatry.

On to Scandinavia!
Oslo - B. A. Hotellet; September 22-27
Stockholm - Terminus Hotel; September 27-October 2
Copenhagen - Excelsior Hotel; October 2-6
Amsterdam - Museum Pension; October 6-10 or 12
Paris, Geneva, Zurich, Rome: only tentative reservations made because of uncertain amount of time needed, will forward specific time when obtained. Can always be contacted through office of Thomas Cook & Son in City or in main office, Berkeley St., London.

Sincerely,

John A. Koltes, M. D.

Hotel Terminus
Stockholm, Sweden
October 1, 1955

Dear Dr. Davis:

I wanted to send you a preliminary report on Scandinavian psychiatry. A fuller review will follow after visiting Denmark. We leave for there in the morning.

First, Norway. It is still suffering badly from the war and has very little money. There are only 100 psychiatrists in the whole country and most of them work in hospitals. Their nursing care is excellent but their hospitals are largely germanic in type and very authoritarian.

Sweden is another dish of tea. This country was not in the war and it is quite evident. There is no destruction or austerity. Indeed, there is considerable money. Their architecture is amazing. Buildings thirty years old are as modernistic in appearance as the U.N. Building. There is a great deal of progress. All construction is designed along functional lines. Their hospitals are fantastic. The Municipal Hospital of 2000 beds has no ward larger than four beds; the same for Karolinska Institute, the University of Stockholm Hospital. I met Professor Sjogren (pronounced Shergren), who is head of the Department of Psychiatry at Karolinska. He is a fine gentleman who has spent a lifetime in genetic research. Most of their interests here are somatic and their orientation is largely biological. Their new closed hospital has 2000 patients, sixteen ward doctors, and five consultants, two of whom are full time. Hospitals permit private practice at the discretion of the superintendent which encourages men to go into hospital work (hospital provides the office at a rate of 60¢ per private patient). They have a National Health Service - it differs from England in that the doctor in Sweden collects from the patient who in turn collects part of the fee from the government. Private practice exists and the doctor can charge the patient whatever he wishes.

I spent the day with Professor Rylander, a forensic psychiatrist who has an NP unit at the Central Prison of Stockholm. Their jail system is more liberal than ours and more progressive. The McNaughton rule was abolished and replaced with the concept that the presence of psychosis or severe neurosis in the accused is sufficient to warrant treatment in mental hospital. Many prisoners are on parole to an interested lay person, the latter secured as we select our citizens for jury duty. Castration is used for some sexual deviates; it is entirely voluntary. Sweden is not a puritanical country as is England and the U. S. There are many differences in the moral code. People more independent here; they are a different kind of people than the Norwegians who resemble the English in culture and mores more closely.

I feel that the Swedes are magnificent architects and a socially progressive group but that therapy of the mentally ill and internal hospital design is lagging. Their treatment of the criminal seems more liberal than the treatment of the mentally ill. Small wards and an opportunity for private practice was very impressive. Private practice reduces the general cost because the doctor supplements his income so that a salary comparable with others is attained but not paid entirely by the state. Hospitals with no private practice pay the doctors more to make up the difference.

Kindest regards,

John A. Koltes, M. D.

Museum Pension Hotel
Amsterdam, Holland
October 9, 1955

Dear Dr. Davis:

We finished our Scandinavian tour this past week, coming down to Amsterdam from Copenhagen this last Thursday. Although it doesn't look far on the map, it's a fifteen hour journey by boat and train.

As you know, I visited hospitals in all three Scandinavian capitals. Each has something distinctive about it, some good, some open to question. By and large, the hospitals are up to date with all of our methods, or at least knowledge of them. They are all well organized and efficiently operated.

Stockholm and Copenhagen divide their hospitals into two groups, those operated by the state and open to all of the people of the country, and those open only to the citizens of a certain town which supports the hospital. Karolinska Institute is an example of the former in Stockholm; Sct. Hans Hospital, Roskilde, Denmark, is an example of the latter. There also are psychiatric clinics of two types - those taking only neurotics or mild psychotics such as the Psykiatrisk Klinik in Oslo and those taking any type of mental illness like Ulleval Sykehus in Oslo (a municipal city general hospital with a psychiatric department). There are also state hospitals for alcoholics (a big problem in Scandinavia) and hospital-prisons for criminal psychopaths. Denmark and Sweden believe in castration for chronic sexual offenders and feel that they have obtained good results.

Sweden has the best physical plants of any country. They also have the most resources. But the other two countries attempt to approach Sweden's beautiful buildings by redecorating and remodeling the interiors of old hospitals. At Sct. (Saint) Hans Hospital, Roskilde, Denmark, for example, they have converted old buildings built in 1880 of large barn-like dormitory construction into eight bed units. All have excellent nursing care. At Sct. Hans. they have gone one step further and also divided the hospital administratively. In a hospital of 2000 beds, they have four Superintendents of equal rank, all responsible to the Minister of Health. There are also four separate staffs. The feeling was that the hospital was too large so they divided it into four groups of 500 patients each. Each department, called A, B, C & D has about seven or eight doctors. As a result, the Superintendent and each of his staff can be well acquainted with the patients for which they are responsible. There is a Neurosis Unit, one building for men and one for women, of very modern design where patients may stay from two to three months. All of the routine forms of treatment (psychotherapy, O. T., group therapy, gardening) are available.

All of the Scandinavian countries, as throughout Europe, have a government health program which bears the cost of medical care through taxation. None are as comprehensive (or as stifling) as England's. They are partial payment plans. Sweden's seemed the most attractive of the three. In this one, the patient pays the doctor and collects from the government insurance company. In the other plans, if the patient has his medical needs cared for under National Health, the doctor fills out endless forms in order to collect from the government. There seems to be more private practice in all these countries than in England.

Treatment in Scandinavia is less well developed than descriptive psychiatry. This is especially true with regard to a dynamic approach to the patient. Patients are referred to as cases and great care is made to see that the authoritarian role of the physician is not violated. One could not walk through a hospital without wearing a white coat and the escorting physician was always careful to walk on my left. There is a germanic, militaristic atmosphere about many of the institutions which makes dynamic psychotherapy or description of the patient difficult. The various staffs tend to think mostly in physical terms varying of course from hospital to hospital. Dikemark Hospital is a good example where foci of infection is thought to be the cause of schizophrenia and where a large staff of internists search for the foci. Treatment is mostly somatic; research is mostly genetic. All three countries keep accurate records of hospital admissions, family illnesses, etc., which are very helpful to those doing genetic research. The relative smallness of each country also permits a good opportunity for this type research. Although it would not be generally applicable to the U. S., it perhaps is the individual states. Professor Sjogren from Karolinska is sending on a genetic study of a Swedish city.

Professor Rylander at the Langholmen Prison, Stockholm, and Dr. Georg Sturup at Hersted Vester, Denmark, are psychiatrists interested in the treatment of criminal psychopaths. Professor Rylander has a 75 bed unit within the prison walls, the largest prison in Sweden. Criminality is treated more leniently there than by us and probation and "living out" is commonly used. Hersted Vester has a 200 bed unit for criminal psychopaths. It is a prison run by a psychiatrist who is interested in rehabilitating this type patient. Dr. Sturup is an advocate of castration for certain sex offenders. 160 have been done in Denmark since 1929 and they report no recurrences of sexual assault in any of those operated on.

Psychiatric training is not as well defined in Scandinavia as it is in the U. S. There is no formal examination. One becomes a specialist by serving a certain amount of time in hospital work. Sweden is the most exacting where they require the submission of credentials to a review board composed of the deans of psychiatry who determine whether a candidate has satisfactorily completed a sufficient amount of training.

There are two medical schools in Norway, four in Sweden and two in Denmark. There are about 400 psychiatrists in Scandinavia. At one time and in some places even today, one could not get a position in any of the schools or hospitals if he was in any way identified with psychoanalysis. There is considerable antithesis to it, and it is definitely not well received.

Professor Sjobring at the University of Lund, Sweden, has a system of personality classification of his own in which he divides personality into four categories: 1) Solidity; 2) Stability; 3) Capacity; and 4) Validity. A normal person has a normal amount of all four. People who are ill are classified as plus or minus each quantity and thereby are typed. #1 corresponds roughly on the minus side to hysteria, #2 to emotional stability, #3 to intelligence, and #4 to energy. By this measure a subsolid, hypervalid person is one to avoid! Professor Sjobring (pronounced Sherbring) believes that mental disorders are the result of brain lesions, known or unknown. EEG's are as routine throughout all three countries as CBC's. There is a constant search for physical causes for emotional disturbances.

While in Holland, I am going to study the Municipal Health Services of Amsterdam and Rotterdam which provide psychiatric treatment "on the spot" rather than in the hospital, also sheltered workshops for the chronically disabled and handicapped (due to emotional causes). From here to Gheel Colonly, Belgium, then to Paris. Would be happy to hear from you while in Paris if convenient. Do hope that you are again well and back to things.

Kind personal regards,

John A. Koltes, M. D.

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fuses, count jar rings, strip plastic covering off wire, and do many more tasks. The schizophrenic patients work right along with them. Mr. Meuzalaar stresses two points - the importance of improving production time by better coordination, and the learning of methods of work which will allow the patients to compete favorably in the open labor market. Work is subcontracted from industry and products are not sold on the open market but to the company which has sublet the contract to the unit. In some instances, the director has been able to get some companies to alter methods of manufacture to make the method suitable to his workshop. Patients are paid according to piece-work in part.

I visited the Valerius Klinick in Amsterdam, a 200 bed private neuropsychiatric hospital directed by Professor VanderHorst of the University of Amsterdam. There seems to be more private practice in Holland than in Scandinavia. There is a National Health Service but it is limited to people making less than 6000 guilders ($840) per year. Of course, there are many people in this category. Police, for example, make about 5000 guilders per year. The living cost in Holland is much less than for us, about $\frac{1}{4}$, except for U. S. autos which are more expensive here than in the U. S. At the Valerius Klinick, the patients are divided into National Health (third class patients), second, and first class. The National Health pays 13 guilders per day, the second class patient pays 20 guilders ($2.80) and the first class pay about 30 guilders ($4.20) for total care. They have "movement therapy", a form of dancing and semi-ballet done by the physiotherapy department and thought to be good for chronic psychotics and severe neurotics.

Dr. Rademachers at Gheel Colony (Gheel Rijkskolonie) was most kind in personally escorting me around the Colony. It is located about 45 kilometers east of Antwerp. Gheel is a city of 24,000 people. There are approximately 3,000 patients or as they say in the city, every eighth person is a patient. The Colony was founded in the 13th Century or before, and it is the oldest continuous family care program in the world. But it has more than just historic interest (of which there is great abundance). There is a hospital of 200 beds; the remainder of the patients are in private homes in the community living with normal people. Patients come from all over Europe for treatment here. They are first admitted to the hospital for observation and if considered suitable for family care, are sent to a foster home where they are visited one time per month by a psychiatrist and twice monthly by an R.N. The city is divided into four sectors each with an M.D. and two nurses. Unfortunately, there are no statistics to indicate the specific value of family care here but the timeless nature of the treatment program testifies to its effectiveness.

There are only two other state hospitals in Belgium. The rest are run by religious orders and are either for male or female patients. Although I saw none of these, I have the feeling that there was less organization and activity in psychiatry in Belgium than in Holland. This may be an erroneous conclusion because of limited contacts but it did seem that way. In other words, an organization such as the Dutch Federation for Mental Health in Amsterdam which more or less oversees all psychiatry in Holland showed its effects in the occurrence of new ideas and progress.

In Paris until the end of October, I will report on the hospitals here, especially the Social Rehabilitation Unit at Neuilly, the Salpetriere, and the International Congress on Chlorpromazine.

Regards to all,

John A. Koltes, M. D.

Hotel des Voges
Strasbourg, France
November 1, 1955

Dear Dr. Davis:

I was very glad to get your letter in Paris, although terribly sorry to hear that you had been ill. That certainly was a most unhappy way to spend a holiday and undoubtedly you don't plan any more like it.

I should like to report on my observations of things in psychiatry in France. Generally speaking, French psychiatry seems to be intimately associated with neurology in what may still be a happy marriage. Professor Jean Delay, University of Paris (Sorbonne), is the only professor of psychiatry in all of France. All of the other professors head a department of both neurology and psychiatry. There is no national association which is comparable to our APA, although the Societie Medico-Psychologue approaches it. Psychiatry here seems to be largely traditional with exceptions, such as Dr. Paul Sivadon's Unit at Hospital de Ville Evrard which I will describe below.

The Salpetriere was a fascinating hospital to visit, largely because of the great historic role which it plays. It is a large city general hospital in southeast Paris which has a very large department of neurology. Names like Charcot and Pinel are freely scattered about in the hospital. On the outside, it is a bit worn and frayed but many of the wards are refurnished and are bright and cheerful.

St. Anne's Hospital (Clinic des Alienes) is also in southeast Paris. This is a 1200 bed psychiatric hospital used as a central reception point for the city and contains the psychiatric department of the University. It is here that residents are trained in psychiatry. The hospital may retain patients for total treatment period or may refer them to one of four mental hospitals serving the greater Paris area (Department of the Seine). Treatment methods are the classical ones. The buildings and grounds resembled PGH to some extent. The neurosurgery department has the newest and most modern section. It was here that I attended the meetings of the International Congress on Chlorpromazine. Dr. Fritz Freyhan, the Clinical Director from Delaware State, gave a paper. The meetings were well attended and papers from all over the world were given. Interestingly, European psychiatrists seem quite concerned with allergic reactions to the drug in their patients and in the nurses giving the medication. Yet in talking with Fritz about it, he has no record of any allergic reactions in several thousand doses given at the Delaware Hospital. I have asked for a copy of the papers to be sent to Philadelphia when they are prepared. It should prove to be interesting reading. The meetings lasted for three days and were sponsored by Special, Inc., the parent manufacturers of chlorpromazine. It's a French preparation.

It is said that there is less interest in psychoanalysis in France than there is in England. There is an analytic institute in Paris, one which recently divided following a quarrel into an Institute and a Society. This bit of news sounded familiar to me. Apparently, our American groups are not the only ones with idealogical difficulties.

There is some interest in social psychiatry in France, and this is spearheaded by Dr. Paul Sivadon who has a remarkable unit at the Hospital de Ville Evrard in suburban Paris. I was especially interested in this because it seemed to be characteristic of the progress that is being made in their field and of the interest that is being paid

it. Although this is not the only unit in France, it is one of the best known. The hospital is a 1200-1400 bed chronic mental hospital built 50-75 years ago. Most of the buildings are locked and the treatment is of the traditional type - EST, insulin, occupational therapy, hydrotherapy, etc. The hospital is divided roughly into four groups, two male and two female with each group having its own medical staff and being at least partially independent of the other groups. One of these groups, a male service, is headed by Dr. Sivadon, an active, imaginative, inspiring kind of person who has taken his very routine service and transformed it into a lively, active therapeutic group. His main methods of treatment are two, a combination of the traditional methods plus workshops where all of the patients are employed. His shops differed from others that I visited, for example, with Max Jones in London, in that he has graduated shops, from playing in sand and smearing paint for deteriorated psychotics to complex machinery for more advanced patients. Patients are either voluntary or certified; of the latter, most are referred from St. Anne's Hospital. There are 300 male patients, three staff, and nine residents. The remainder of the hospital has two residents which perhaps is a measure of the interest shown in an active therapeutic program.

There is also an out-patient service. This meets three times weekly in an old building in southeast Paris (an older, poorer section of the city) which has been converted into a very pleasant hospital unit. Recently, the staff obtained funds for the construction of several beds in the building which will permit them to run a night hospice. This is planned as a place for patients to stay until they are able to find work. Many of the patients with whom they deal are homeless and jobless and have no place to go when well enough to leave the hospital. They often are referred by the police, being picked up as vagrants for causing some disturbance.

The Out-Patient Department is operated by the staff but directed by a resident social worker who acts as a job placement agent and case worker combined. Sivadon feels that specific job-training within the hospital is not important and that the workshops should be geared to the level of the patient. Most of his patients are chronic schizophrenics as compared with Jones' psychopaths. The shops are relatively crude and inexpensively constructed. They are hospital rooms and are staffed by nurses, there being no trained O.T. workers available. The wards are all open and the fences have been removed. This is not so in the other part of the hospital. Music was played through loud speakers in the corridors and old enormous dormitories were sectioned into units of six or eight beds per unit. One dormitory had individual cubicles, each with a curtain across it and walls 2/3 way to the ceiling between each bed for the convalescent group. The only major problem that was apparent was the fact that all of the patients were male which naturally tends toward an incomplete environmental situation, but otherwise the program was very remarkable and fascinating to study.

We are enroute to the Psychosomatic Clinic of Micherlich at Heidelberg and Kretschmer's Clinic at Tuebingen. From Tuebingen (near Stuttgart) we are going on to Zurich to work with Professor Bleuler at the Burgholzli Hospital. I shall report on these as they are completed. The new building and offices at E.P.P.I. sound thrilling. I'm looking forward with great enthusiasm to being with the group.

Most cordially,

John A. Koltes, M. D.

Pension Villa Montana
Zurichbergstrasse 16
Zurich, Switzerland
November 15, 1955

Dear Dr. Davis:

We have come to Zurich by way of Heidelberg, travelling from the University of the one city to the University of the other. Both have been fascinating experiences and have given me a glimpse of German psychiatry which for so many years was a world leader. Kraepelin was Professor of Psychiatry at the University of Heidelberg until his death in 1926. Today, things are different as a result of the war but there is still a great deal to be learned.

The University of Heidelberg appointed a new Professor of Psychiatry the week that I was there, Professor von Baeyer from Nurenberg. He is especially interested in psychotherapy in psychiatry. There is a 200 bed unit on the University campus which provides a splendid opportunity for teaching and training students. They also have a fifty bed children's unit in another building. There are a great many admissions each year to the main psychiatric hospital - some 20,000 but many are for study or evaluation only with no treatment. All admissions receive routinely an electroencephalogram which is common among Germanic hospitals. Scandinavian hospitals also do an EEG routinely on all admissions.

Unfortunately, Professor von Baeyer's appointment was so new that he had not yet reorganized his department. I had the feeling, however, after talking with him at length that he plans to place as much stress on dynamic psychiatry as on laboratory and physical tests in psychiatry. Professor Mitscherlich heads the Department of Psychosomatic Medicine at the University of Heidelberg. He is trained in neurology and internal medicine, and is a practicing psychoanalyst. I was warmly received by him and found him to be most helpful and encouraging. Although an analyst in the true Freudian tradition, he is also interested in social psychiatry and psychotherapy in schizophrenia. He trains residents in analytic techniques only. There is no institute of analysis in Heidelberg or anywhere in Germany. Generally speaking, it is said that people are disinterested in analysis and that training in this specialty may be detrimental to securing a position. In spite of this view, however, there are some small analytic groups about the country. I had the impression that there was as much feeling against analysis in Germany as in England but that England had developed other positive approaches to psychiatric problems, whereas this did not appear to be as evident in Germany. The latter country seemed more pessimistic and defeatist. It is amazing to note the difference in character structure and social customs between the two countries. Certainly it is reflected in their psychiatry and their approach to patients. And of course, their philosophical differences are well known. Germany is very patriarchal, has a strong sense of duty, is very formal.

Zurich is a delightful city, a mixture of medieval and modern architecture very beautifully blended so that there is no distinct "old city" and "new city". We came to the University of Zurich and the Burgholzli Hospital. It has been a real thrill to see these two places. They are not located together, the former being in the heart of the city, the latter in the suburbs. I had read Eugen Bleuler's text translated by Brill. Seeing the hospital is the other half of the story.

First - Burgholzli - a 650 bed closed mental hospital operated by public funds. It is the mental hospital (there are two or three other smaller ones) serving the Kanton of Zurich. The University, one of six in Switzerland, is state owned and operated, hence Burgholzli being at the same time a university department is state operated. Professor Manfred Bleuler is the Director. I have attended his lectures to the medical students and sat in on the case conferences. The hospital is divided into male and female services. There are no children. All of the hospital is locked. The plant was built 78 years ago and although standing alone is far from isolated, being located in a suburban residential area overlooking the Lake of Zurich.

Professor Bleuler's interest is largely in the endocrinology of psychosis. Last year, he published a book surveying 5000 papers on schizophrenia. Unfortunately, it is unpublished in English, lacking a translator. He also published this year a new edition of his father's textbook of psychiatry. It too has not been translated, the last translator being Brill. I think something might be done along the lines of at least reviewing this volume for it is a good "middle-of-the-road" standard textbook of psychiatry.

I was surprised to learn of the conservatism that pervades the philosophy of treatment. Deep insulin and electroshock are used infrequently. Serpasil and chlorpromazine, barbiturate and morphine narcosis and early discharge are much more highly thought of. On an active service of 100 women, there were only three on deep insulin. EST is given only two times per week to about the same number of patients. Early discharge, ambulation and constant activity are looked upon as very important phases of treatment. Burgholzli has always championed early discharge from the time of the first Bleuler. Once a patient is discharged, he is not followed as a rule. Frequent admission to the hospital is common. Financial costs are not too much of a problem. There is an insurance program to which everyone subscribes. Patients are classed as one, two or three depending on their ability to pay. Types of rooms determine the class within the hospital, from third class wards to first class private rooms.

The hospital reminds me of Friends Hospital in design and external appearance, although it did not seem to be as comfortably furnished or as warm and friendly as Friends Hospital.

The Burgholzli has no O.P.D. at the hospital but does have a clinic in the center of the city on the University campus. Since few patients are referred for O.P.D. care, most of the patients seen in the O.P.D. come from other sources.

Perhaps one of the most interesting things at Burgholzli was the Institute of Medical Psychotherapy which is a group of physicians who have started an analytic institute for training residents. The institute is neither Freudian nor Jungian but bases its theories on the philosophy of Martin Heidegger, the contemporary German philosopher. A type of psychotherapy with a distinct existentialist coloring is used. Benedetti, the analytic psychotherapist of the hospital who was trained by Rosen in New York, also utilizes these principles. It is fascinating to see a group of physicians working in a hospital of this magnitude utilizing an entirely different philosophic system in their treatment of patients. One of them, Professor M. Boss, has written a textbook (Meaning and Content of Sexual Perversions, Grune & Stratton, 1951) and a book on psychosomatic medicine using the principles of Heidegger's philosophy of "existence" or "being in the world" for a basis of psychosomatic theories.

I want to get over to WHO in Geneva and to Vienna. Then from here we will journey to Rome to visit Professor Cerletti. I shall have more to report on the University Hospital and Out-Patient Service soon, including the Family Service of Burgholzli.

Hope that all is well on Henry Avenue. Sure looking forward to joining you there.

Kindest regards,

John A. Koltes, M. D.

Hotel Austria de la Ville
Venice, Italy
November 28, 1955

Dear Dr. Davis:

Burgholzli, University of Vienna, and University of Padua are the last three hospitals visited. In my last letter, I discussed some of the characteristics of Burgholzli and mentioned that I would finish up with the O.P.D. and the Family Service.

One of the chief principles of Burgholzli is early discharge from the hospital as soon as the patient is considered well enough to make some sort of social adjustment. He does not have to be well before discharge is attempted. I presume that early discharge was aided by close follow-up in the OPD but this is not the case. Quite the contrary, few in-patients are referred for OPD follow-up. They are not followed but are allowed to "go it alone" or under the care of their local physician. This is done on the theory that hospitalization provides the best treatment and that anything other than this is inferior. Although such an approach is understandable, it didn't impress me as being one based on dynamic principles. And, of course, re-admissions to the hospital are common. One interesting thing that is done is the photographing of a patient at the time of each admission to see the facial changes on repeated re-admissions.

The OPD is not located with the main hospital, which is in the suburbs, but is on the grounds of the University Hospital in downtown Zurich. The OPD has a new building of its own - a long low type affair with half of it given to offices and half to twelve beds for a small in-patient service. There are four physicians, all of whom have been trained in the analytic institute with which Bleuler is associated. The patient group is divided roughly into thirds - 1/3 referrals for psychiatric evaluation for possible abortion, 1/3 referrals for forensic evaluation for the court, and 1/3 voluntary patients in psychotherapy.

The in-patient beds are used for the study of cases of psychosomatic nature or for chlorpromazine treatment. Patients are rarely given chlorpromazine or serpasil as out-patients. They are admitted to the hospital or the OPD, placed in a semi-darkened room and treated with much attention and nursing care. This is generally characteristic of the method of use of the drug here where a ritual is made of it just like EST or deep insulin. The patient is told that he is going to be admitted for "largactil kur" and is then placed in this very dependent, permissive situation which may explain in part why European physicians generally use much less of the drug per 24 hours than we do. 300 mgm. daily is average; 500 mgm. is a very high dose. EST is never given to out-patients. It is considered to be too dangerous for this. The psychotherapy is generally of an analytic type either Jungian, Freudian, or Existentialist. The latter is relatively new here and an analytic group of Existentialists is starting. Professor Bleuler offers patients from the Burgholzli as controls so that this offers quite an enticement to those interested in it.

One outstanding feature of the Burgholzli is that all branches of psychiatry, from the orthodox organicist to the pure psychoanalyst, are represented here and they get along together. I think that there is a lesson to be learned in that. If we are going to have a hospital which approaches the problems of psychiatry in the broadest perspective, we need to be aware of ways by which each discipline can live together and work together. It was much more stimulating to see this in process in Zurich than to think of how some of our societies have split apart or how the same has happened in other cities. Bleuler maintains that an interest in the hospital by divergent groups has been maintained by his remaining apart from identifying strongly with any one group to the detriment of any other group. Although he has principles

and theories of his own, he has not deprived others of an opportunity to express their views all together and all under the same roof. This, to me, is the true university where search for new knowledge is more important than anything else.

The Family Service of Burgholzli is run by Dr. Stoltz, the man who did the original work clinically on lysergic acid. He knows all of the families and works half day at the hospital, half day visiting patients kept by families. About 200 patients are boarded out. Apparently the system works very smoothly and with very few hitches. If someone is not doing well, he is immediately returned to the hospital or the family is changed.

Let me tell you of the University of Vienna. I shall never forget my visit there, for it was one of the highlights of the trip. Everything worked very smoothly and I was warmly received by the staff.

I left my family in Zurich and took a night train through the Austrian tyrol for Vienna, a fifteen hour ride. It was snowing in Vienna, the first of the season. The Russians had left very recently and one somehow could feel the enthusiasm of the people. They were cordial and friendly. And, of course, they had their opera back, the first time for many years. But more of that later.

Professor Hans Hoff has a big service at the University. He is Chief of Neurology and Psychiatry. The building is located with the other departments (medicine, surgery, etc.), each in a separate building on the east end of the city near the Allgemeinkrankenhaus, the famous general hospital of Vienna. His department has 360 beds - 2/3 psychiatry, 1/3 neurology. Professor Hoff is a professor in the true sense - like Professor Bleuler, "the" professor to whom everyone gives allegiance. It is amazing to see how dutiful and courteous these people are to their professor. He is treated as a kind of supernatural being toward whom everyone pays great respect. This was most noticeable on making rounds where the patients, even disturbed psychotics, stopped talking, removed any headgear they may be wearing, and stood up when the professor entered. It must be understood in Austrian terms, not American terms, for to us it is most unusual. It was fascinating to observe and points up the importance of the European feeling for a strong patriarchal society.

The University Hospital is the only N.P. service in Vienna. The Allegmeinkrankenhaus does not have one, so that the University acts as a receiving, acute treatment and disposition service. Chronic patients are referred to mental hospitals. (There's something wrong with doing that - I have some ideas on it but not the space to discuss it here except to say that I feel that wherever possible, the admitting hospital should keep the patient until well enough for discharge; transfer to a chronic hospital is demoralizing to the patient, annoying to the chronic hospital staff, and a relief to the physician on the acute service.)

Chlorpromazine and serpasil with the other physical methods of treatment are widely used. There is a department of psychotherapy where one can get a classical Freudian, Jungian, or Adlerian analysis, counselling, group therapy, or short-term psychotherapy. There are extensive laboratories in the basic and clinical fields - an electron microscope, a new microtome capable of cutting tissue to 100 A., a research physician who has isolated and repeated filtered from the cerebrospinal fluid of patients with multiple sclerosis an acid fast organism. He also is studying the A/G ratio of these patients and by a spectrgraphic method, has determined new methods for measuring the globulin fractions, thereby being able to accurately predict an exacerbation of multiple sclerosis before it occurs according to what is happening to the patient's A/G ratio. It was fascinating to talk to him, and I was

much impressed although it is too early to know the significance of this. Only some of the data is published - of which I have a copy. There was less pessimism here than in some of the other hospitals. There was a feeling of progress, of organization, and of satisfaction in doing a job well. The place was literally a beehive of activity much like the Maudsley in London, each person doing his own work, each a piece of research but the whole service controlled by one person who knew something of the workings of each department; Professor Aubrey Lewis in London, Professor Hans Hoff in Vienna.

On the lighter side (there are some other details of the hospital for our further thought but not for here), there was opera in Vienna; opera at two houses, seven nights a week! I was thrilled to see the new Vienna State Opera in a performance of "Der Rosenkavelier". It was magnificent. The people were so enthusiastic that there were five and six curtain calls between each act - a magnificent spectacle.

The University of Padua, that venerable place near Venice, was my introduction to Italian psychiatry. Here, the Italians are more organic and less analytic than the Germans and the Swiss. Sad to say, their psychiatry has very little dynamic quality and is almost entirely organic in treatment. Of course, they were the ones who gave us electroshock, and that is why I am here.

Will let you know of our findings in Italy and especially the University of Rome, which will be the closing chapter to our European junket.

Most cordially,

John A. Koltes, M. D.

Hotel Londres
Naples, Italy
December 8, 1955

Dear Dr. Davis:

We have come to the end of our journey in Europe. It has been a most successful experience and an unforgettable opportunity to learn many things. I owe a great debt of gratitude to you, to the Board members of Eastern Psychiatric Institute, and to the Secretary of Welfare for making this experience possible. Through application of the things that I have learned here I hope to repay all those responsible for my trip.

As a way of describing some of the things that I have learned, I have written an outline for a second paper. It is tentatively entitled: "Toward an Integrated Approach to the Problems of Psychiatry" and comprises a survey of the major schools of European psychiatry together with a somewhat philosophical discussion of training, teaching, and research in psychiatry. Perhaps it can be used in part as a platform for the program of the Institute. I would be happy indeed to have you write part of it as co-author if you wish. For the moment, it strikes me as a rather important guide post although my perspective may be somewhat clouded by my enthusiasm. Nonetheless, I plan to go ahead with it and, if appropriate, we can consider publication at a later date.

Let me tell you about the University of Rome while it is fresh in my mind. I talked with Professor Cerletti, the inventor of electroshock. The conversation was not too lengthy because he speaks Italian, French and German and only little English so we got along as best we could in French. In 1950, at the International Congress of Psychiatry in Paris, he reviewed his work up to that time. I do not have a copy of this paper but think that it would be very helpful for those interested in basic research. Professor Cerletti retired from the directorship of the department four years ago and was replaced by Professor Mario Gozzano from the University of Bologna. The latter, a most gracious person, is more interested in social sciences and psychotherapy than is Professor Cerletti so that there now is more stress on psychotherapy than formerly.

The University Unit is again a hospital characteristic of European psychiatric services. It is a department of neurology and psychiatry both in the same building. They have only eighty beds and the staggering number of twenty to thirty admissions <u>every day</u>. This, of course, presents tremendous problems for them, and treatment is brief to say the least. Physical forms of treatment are extensively used, both in the in-patient and out-patient departments. Generally in Europe, electroshock is not used on out-patients but it is at the University of Rome. The University Hospital and the city hospital are one and the same. There is no other city hospital. By and large it is operated in the Germanic tradition of director and subordinates. This is so because many of the department chiefs were trained in Germany.

One evening I attended a lecture sponsored by the Cultural Society of Austria and Rome at the University. It was given by Professor Hoff of Vienna and was on the subject of Multiple Sclerosis. He discussed the findings of his research group in that particular field, of their isolation of the TB-like organism, the A/G ratio studies, and the use of Rimiform in treatment. It was good to see him again, although I had seen him only a short time ago in Vienna. To date, I have not been able to locate anyone with a specific opinion of this work. It will be very interesting to talk with the neurological people at home of their opinion of this work.

There is an Analytic Society in Rome of about 50 members and a very small Jungian group. Analysis is not well received in Rome, nor apparently anywhere in Italy. Some say that this is due to the German influence, others venture no opinion. At any rate, training in analytic work is very limited. Existentialism has its place here just as it does in Zurich. There is an attitude of pessimism and a certain feeling of hopelessness which I sensed. This is due partly to the great number of doctors, the limitations of private practice, and financial problems. There are 90 doctors on the staff of the University Clinic. Ten are full time. The others are half time for which they receive no pay. They do this work voluntarily because of the prestige value of a university association. It is said that there is not enough work available for full time practice, although I talked to only one person about this and would think it open to question. He seemed unduly pessimistic although he sounded like many other European psychiatrists - pessimistic, cautious, critical. Every time a younger person comes up with an idea, he must show that it has not been thought of before and must demonstrate its worth. Of course, such an attitude tends to promote scientific truth and to dispel the erroneous, the ambiguous, and the uncertain. It is one of the reasons why analytic theory has not done well in Europe - it is not able to tolerate a scientific, experimental approach. And, I suppose that this may be one of the reasons why European psychiatrists have given us EST, insulin, chlorpromazine, lobotomy and psychoanalysis.

These ruminations I hope to get down in some form and use as the basis for a paper mentioned earlier in this letter. As I have travelled from country to country, I have become increasingly impressed with the need for a broad perspective, for an open mind, and for an awareness of what others have done in medicine, the social sciences, philosophy, and theology. It seems to me that one ought to have some knowledge of all of these things and a lot of knowledge of one of them. For myself, I have been drawn to the principles of social psychiatry, a method of treatment in psychiatry which seems to apply the greatest good to the greatest numbers. It is not individual treatment as I understood it, but applies the principles of individual treatment to large numbers of people. I have seen many good things come of this method while in England and would hope to utilize this experience at home. One advantage of it is that it doesn't cost any more than what is already being spent so that from that side, at least, we need have no major battles for money before being able to demonstrate what we can do.

It is unnecessary to say that we are anxious to come home and get started at the new hospital. We have been in twelve countries here, and I have visited over fifty hospitals. All of us have thrived on it and are hale and hearty. On the lighter side, we have taken many pictures in our travels and look forward to showing them.

Trust that all is well with you and that you are entirely well again and in top shape. Our best to the group.

Most cordially,

John A. Koltes, M. D.